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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G193	A. BUILDING _____ B. WING _____	R 07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW 02	74 'W' ST, NW WASHINGTON, DC 20015

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{W 000}	INITIAL COMMENTS Another follow-up survey was conducted on 7/13/10 - 7/15/10 to verify that the facility had come into compliance with deficiencies identified in the previous follow-up survey on 6/10/10. The governing body submitted a Plan of Correction dated 7/12/10. The follow-up visit revealed that there had been significant progress made since the 6/10/10 follow-up survey. Through observation, interviews with staff and residents and review of records, the determination was made that the facility was in substantial compliance with the Conditions of Participation of Governing Body, Client Protections and Health Care Services. However, there remained some standard level deficiencies, as evidenced in the report that follows.	{W 000}	All individuals that resided at 74 W Street have moved to other facilities. One of the individuals chose another agency. Two individuals moved to an ICF. Two other individuals moved to a wavier facility. It is the intent of the administration of MarJul Homes, Inc. to see that any and all deficiencies cited on the individuals residing in our homes are being addressed. The administration recognizes the important role the consultants plays in ensuring the quality of life for the indivudauls we serve. in an effort to ensure the hightest quality, all consultant contracts are under review. Some contracts will be terminated due to not honoring thier commitments. New consultants will be hired where needed. We have also met with the DCHRP and they have offered thier assistance and support. We will be taking advantage of this offer. See attachment.	
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for five of the five clients residing in the facility. (Clients #1, #2, #3, #4 and #5) The findings include: 1. [Cross-refer to W189 and W249] The QMRP failed to ensure that all direct support staff	{W 159}	1.In each facility systems are being put in place to ensure that staff receive training on consistent implementation of client's behavior support plans.	8/11/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 159}	Continued From page 1 received training on consistent implementation of clients' behavior support plans. According to the QMRP, all five clients had behavior support plans. 2. [Cross-refer to W189 and W252] The QMRP failed to ensure that all direct support staff received training on consistent and accurate documentation of behavioral incidents. 3. [Cross-refer to W192] The QMRP failed to ensure that direct support staff who were assigned to meal preparation duties were effectively trained on provision of Client #3's prescribed high fiber diet. 4. There was no evidence that the QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Client #3. On 7/13/10, interview with the Director of Nursing by telephone revealed that the facility had just entered into a contract/agreement with a speech/language therapist on the day before (7/12/10). She further indicated that to date, Client #3 had not received a speech-language screening. This was verified through review of Client #3's record on 7/14/10. This is a repeat deficiency. _____ Previously, the 6/10/10 deficiency report included the following: 2. [Cross-refer to W189.1 and W252] The QMRP failed to ensure that direct support staff received training on consistent and accurate documentation of behavioral incidents.	{W 159}	2. The QMRP, and subject to the review by the Quality Assurance Specialist, will ensure that all direct care staff receive training on consistent and accurate documentation of behavioral incidents. 3. The QMRP, and subject to the review by the Quality Assurance Specialist, will ensure that direct support staff are effectively trained on the prescribed diets of all individuals. 4. The contract for the speech-language consultant has been signed. An assessment by the consultant for Client # 3 is scheduled. See attachment. See W 159 #2	8/18/2010 8/18/2010 8/18/2010 8/18/2010

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{W 159}	Continued From page 2 6. [Cross-refer to W460.2] There was no evidence that the QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Client #3. Citation W460 in the federal deficiency report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the client was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10, at approximately 5:10 p.m., a direct support staff was observed in the kitchen, chopping food with a knife. When asked, she stated that she and other staff always chopped Client #3's foods to help his swallowing. However, review of the client's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup	{W 159}	See W 159 #4	8/18/2010

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{W 159}	Continued From page 3 twice daily." [It should be noted that on 6/2/10, a new nutritionist wrote "<Client #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... <Client #3> should receive a ground texture."] This is a repeat deficiency. --- Previously, the federal deficiency report dated 5/3/10, included the following: 1. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective for Clients #3 and #4. [See W252] 2. The facility's QMRP failed to coordinate services to ensure menus were modified as necessary to provide the prescribed diet of Client #3. [See W460]	{W 159}	1 a. The QMRP will train the direct care staff on consistent documentation on the Individual Program Plan, subject to the review of the Quality Assurance Specialist. 2 a We are in the process of securing the services of a new nutritionist who will assess all individual diets and ensure that all DSP's and management staff are trained on the effective implementation of the prescribed diets of all individuals. The management staff will be required to observe the preparation and implementation of the prescribed diets.	8/18/2010 8/18/2010
{W 189}	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff was effectively trained on implementing clients' behavior support plans and documenting targeted maladaptive behaviors in the clients' behavior	{W 189}		

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{W 189}	Continued From page 4 data, for 6 of the 13 direct support staff in the facility. The findings include: 1. [Cross-refer to W249 and W252] On 7/14/10, at 5:45 p.m., Client #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the client was standing alone. However, a direct support staff person began speaking with him from the nearby dining room. The staff did not encourage him to button up and/or zipper his jeans while they conversed. On 7/15/10 at 3:35 p.m., review of Client #3's behavior data forms revealed that staff had not documented the 5:45 p.m. episode from the previous evening as required by Client #3's behavior support plan (BSP) dated 4/19/10. Moments later, at 3:40 p.m., the qualified mental retardation professional stated that "staff should direct him to zip his pants up, if he refuses then staff would do it for him." The staff had not, however, been observed implementing the intervention strategies as outlined in the BSP. The facility documented having provided training on clients' programs and data collection on 7/9/10 and 7/13/10. Staff in-service training records were reviewed on 7/14/10. At 11:55 a.m., review of the staff signature sheets revealed that the male staff person who failed to instruct and/or assist Client #3 with zipping his zipper (later that afternoon, at 5:45 p.m.) had received training on the previous evening (7/13/10). There was no evidence that the training presented on client programs and data collection had been effective.	{W 189}	See W 159 # 2	8/18/2010

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{W 189}	Continued From page 5 2. In addition, further review of the 7/9/10 and 7/13/10 signature sheets revealed that 7 of the 13 direct support staff had attended the trainings. There was no evidence, however, that the other 6 staff had received training on client programs and data collection. This is a repeat deficiency. Previously, the 6/10/10 deficiency report included the following: [Cross-refer to W252] On 6/9/10, at approximately 8:15 a.m., Client #3 was observed to remove all of his clothing while standing in the living room. Review of his records the next day, at 8:55 a.m., revealed that the staff who were on duty at the time failed to document the incident in on his behavior data sheets. Another behavioral incident was indicated in a staff log entry on 6/6/10; however, it too had not been documented in the program book, in accordance with the client's behavior support plan (BSP), dated 4/19/10. On 6/9/10, at approximately 3:15 p.m., interview with the qualified mental retardation professional (QMRP) revealed that the facility had not provided in-service training since new management was appointed by a court on 5/14/10. This was corroborated a short time later (4:05 p.m.) by two direct support staff who were interviewed.	{W 189}	N/A	
{W 192}	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed	{W 192}		

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{W 192}	Continued From page 6 toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to implement prescribed diets, for one of the five sampled clients. (Client #3) The finding includes: [Cross-refer to W460] On 7/13/10, at approximately 5:15 p.m., interview with the direct support staff person who was preparing dinner in the kitchen revealed that all 5 clients, including Client #3, had received apple sauce for snack. Moments later, review of a list of "low fiber" foods that was posted on a kitchen bulletin board revealed that apple sauce was among the food items considered "low fiber." There was no comparable list of "high fiber" food items posted in the kitchen. Client #3, who had already finished his apple sauce at the time, had physician's orders that prescribed an "increased fiber" diet. The staff person had prepared stir-fried vegetables with chopped turkey meat, to be served over white rice. When asked about Client #3's prescribed high fiber diet and how the facility ensures that his meals are high in fiber, the staff person indicated that she wasn't sure and then referred this surveyor to two other (male) staff who had been "working here longer." Review of the menu she had used for that evening's meal revealed that it did not address high fiber diet plans.	{W 192}	See W 159 #2a	8/18/2010

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{W 192}	Continued From page 7 Staff in-service training records were reviewed on 7/14/10. The facility documented that on 6/14/10, the nutritionist presented training on prescribed diets. At 1:30 p.m., review of the 6/14/10 signature sheet revealed that the staff person who prepared the 7/13/10 dinner (and who was interviewed) did not attend the nutrition training. Only one of the two male co-workers she had mentioned by name had attended the training. In addition, review of the training materials used on 6/14/10 revealed a list of high fiber foods that recommended brown rice for increased fiber. On 7/13/10, however, Client #3's stir-fry was served over white rice. This is a repeat deficiency. _____ Previously, the 6/10/10 deficiency report included the following: [Cross-refer to W460] On 6/9/10, at 4:16 p.m., Client #3 was offered sugar wafers for afternoon snack. The nutritionist, however, had recommended that he receive hi-fiber snack items, in part to address recurrent bouts of constipation and fecal impactions. Interview with the direct support staff on 6/9/10, at approximately 5:10 p.m., revealed that she was previously unaware of the recommended high fiber snacks. She stated that she had not received any training on diet plans and snack choices. She further indicated that there was no list of high fiber snacks available for staff reference. On 6/9/10, beginning at 3:11 p.m., the qualified mental retardation professional (QMRP)	{W 192}		

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{W 192}	Continued From page 8 stated that the facility had not provided staff in-service training since the new management team was appointed on 5/14/10. This was also verified through review of training records on 6/10/10, at approximately 1:00 p.m. [Note: On 6/10/10, at 2:50 p.m., the QMRP pointed to announcements posted in the facility, for mandatory staff training by the nutritionist. It was scheduled for 6/14/10.]	{W 192}		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement client behavior support plans, for one of the five clients included in the sample. (Client #3) The finding includes: Observation on 7/14/2010, at 5:45 p.m., Client #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the client was standing alone. However, a direct support staff person began speaking with him from the nearby dining room. The staff did not encourage	W 249	See W 159 #2	8/18/2010

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W 249	Continued From page 9 him to button up and/or zipper his jeans while they conversed. On 7/14/2010, at 9:35 a.m., review of Client #3's behavior support plan (BSP) dated 4/19/10, had revealed "Disrobing" or "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive behaviors identified in the BSP. In an interview with the qualified mental retardation professional (QMRP) on 7/15/2010, at 3:40 p.m., she stated "staff should direct him to zip his pants up, if he refuses then staff would do it for him."	W 249		
{W 252}	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objectives, for one of the five clients in the sample. (Client #3) The finding includes: Observation on 7/14/2010 at 5:45 p.m., Client #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the client was standing alone. However, a direct support staff person began speaking with him from the	{W 252}	See W 159 #1a	8/18/2010

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{W 252}	Continued From page 10 nearby dining room. The staff did not encourage him to button up and/or zipper his jeans while they conversed. On 7/14/2010, at 9:35 a.m., review of Client #3's behavior support plan (BSP) dated 4/19/10, had revealed "Disrobing" or "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive behaviors identified in the BSP. According to the Frequency of Targeted Behavior Form and the ABC Data Collection Sheet, staff should document each episode of a targeted behavior that was observed. Review of the aforementioned forms on 7/15/10 at 3:35 p.m., revealed that staff had not documented the 5:45 p.m. episode from the previous evening on the ABC Data Collection Sheet. In an interview with the qualified mental retardation professional (QMRP) on 7/15/2010, at 3:40 p.m., she stated "staff should direct him to zip his pants up, if he refuses then staff would do it for him." This is a repeat deficiency. --- 1. Observation on 6/9/2010, at 8:06 a.m., revealed Client #3 removed his shirt, threw it across the room, dropped his pants and stood naked next to the sofa. The direct support staff immediately intervened, instructing him to put his clothes back on, while other staff quickly escorted the other clients out of view. Client #3's behavior support plan (BSP) dated 4/19/10, was reviewed the next morning	{W 252}		

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{W 252}	Continued From page 11	{W 252}		

(6/10/10), beginning at 8:38 a.m. "Disrobing" or "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive behaviors identified in the BSP. According to the Frequency of Targeted Behavior Form and the ABC Data Collection Sheet, staff should document each episode of a targeted behavior that was observed. Review of the aforementioned forms on 6/10/10 at approximately 8:45 a.m., revealed that staff had not documented the 8:15 a.m. disrobing episode on the ABC Data Collection Sheet. [Note: Staff had documented another episode of disrobing earlier that morning, at "7:30 a.m. ...just before breakfast."]

2. On 6/9/10, at approximately 3:30 p.m., review of the Daily Log Book (in which staff documented their activities throughout their shift), revealed the following entry dated 6/6/10, at 6:00 a.m. "<Client #3 stripped totally and wet on the sofa; sofa cleaned and left to dry out." Review of the ABC Data Collection Sheet on 6/10/10, at approximately 8:45 a.m., revealed that there was no documentation of the observed targeted behavior.

This is a repeat deficiency.

Previously, the federal deficiency report dated 5/3/10, included the following:

The facility failed to ensure that data was consistently maintained on the training objectives designed to improve behavior of Clients #3 and #4, as evidenced below:

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{W 252}	Continued From page 12 a. Observation of Client #4 on 4/29/10, at approximately 6:19 p.m., revealed she began talking to herself, as she repeatedly hit herself on the left side of her head ... Review of Client #4's behavior support plan (BSP) dated 8/17/09, on 4/30/10 at 9:24 a.m., revealed the client exhibited self-injurious behaviors (SIB), which included punching herself on face or head. According to Frequency of Targeted Behavior Form, the face slapping/punching behavior should be documented. The ABC Data Collection Sheet also required that antecedents, behaviors, interventions, and responses to the intervention be documented each time staff observe the client exhibit a targeted behavior. Review of the aforementioned forms on 4/30/10 at 9:35 a.m., revealed that the face slapping observed by the surveyor on 4/29/10 during the medication administration had not been documented. b. Observation of Client #3 during the medication administration on 4/29/10, at 7:26 p.m. revealed he slapped himself repeatedly on the right side of his face... He then got up from the chair, cursing loudly, and began "puffing and blowing" ... There was no documentation on the ABC Data Collection Sheet concerning the observed targeted behavior.	{W 252}		
{W 460}	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the therapeutic	{W 460}	See W 159 #2a	8/18/2010

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{W 460}	Continued From page 13 diet was provided as prescribed, for one of the five clients in the sample. (Client #3) The finding includes: On 7/13/10, at approximately 4:50 p.m., Client #1 was observed with a bowl of apple sauce. He indicated that this was his afternoon snack. At approximately 5:15 p.m., interview with the direct support staff person who was preparing dinner in the kitchen revealed that all 5 clients had received apple sauce for snack. Moments later, review of a list of "low fiber" foods that was posted on a kitchen bulleting board revealed that apple sauce was among the food items considered "low fiber." Client #3, who had already finished his apple sauce at the time, had physician's orders that prescribed an "increased fiber" diet. It should be noted that the facility had documented that on 6/14/10, the nutritionist presented training on prescribed diets. Among the materials used at the training was a list of high fiber foods. This is a repeat deficiency. _____ Previously, the monitoring survey conducted from 4/29/10 to 5/3/10 revealed Client #3 had a history of bowel obstruction and multiple emergency room (ER) visits due to constipation. Observation, interview and record review during the follow-up survey conducted on 6/9/10 and 6/10/10, revealed that the facility failed to ensure Client #3 was provided a modified (high fiber) diet in accordance with his assessed needs. For instance, on 6/9/10, Client #3 and his peers were given sugar wafers for afternoon snack when his	{W 460}		

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{W 460}	Continued From page 14 physician's orders called for high fiber snacks.	{W 460}		

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{R 000}	INITIAL COMMENTS Another follow-up survey was conducted on 7/13/10 - 7/15/10 to verify that the facility had come into compliance with deficiencies identified in the previous follow-up survey on 6/10/10. The governing body submitted a Plan of Correction dated 7/12/10. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with 22 DC Municipal Regulations, Chapter 47, Health Care Facility Unlicensed Personnel Criminal Background Checks, as evidenced in the report that follows.	{R 000}		
{R 125}	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and review of personnel records, the Group Homes for Persons with Mental Retardation (GHMRP) failed to ensure timely criminal background checks for all jurisdictions in which the employees had worked or resided within the 7 years prior to the check, for 5 out of 13 direct support staff whose background check documentation was made available for review. (S1, S2, S3, S4 and S8) The findings include: On 6/10/10, during the Exit meeting, the	{R 125}	The administration of MarJul Homes has amended the employee handbook and revised the policy and prcedure manual to stimplate the following: The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check.	8/12/2010

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{R 125}	Continued From page 1 GHMRP's administrator was informed that there was no evidence of comprehensive criminal background checks for 6 out of 13 direct support staff (#1, #2, #3, #4, #7 and #8). The facility's Plan of Correction, signed by the administrator on 7/12/10, indicated that the checks would be secured on 7/14/2010, more than one month later. On 7/14/10, beginning at 1:30 p.m., review of the six employees' personnel records revealed the following: 1. Nationwide criminal background checks were documented for S1, S2, S3 and S8, all of which were commissioned and secured on the morning of 7/14/10. Review of staff schedules revealed that the four employees had continued to work in the facility between 6/10/10 and 7/14/10. [Note: All 4 of the background checks revealed "no records found."] 2. Staff #7 was no longer employed by the agency. His last day with the facility reportedly was 6/10/10; therefore, no additional information was provided. 3. Initially, the facility did not provide evidence of a comprehensive background check for Staff #8. However, at 4:10 p.m., the CEO presented a criminal background check that indicated that she had been charged with "Assault-first degree" and "Assault-second degree" in Prince Georges County Maryland. The date(s) that the charges were filed, and the status/outcome of the charges were not indicated. The report documented that the background check had been performed on 7/14/10 at 10:14 a.m. Shortly thereafter, at 4:35 p.m., Staff #8 was placed on administrative leave, pending further investigation.	{R 125}		

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{R 125}	Continued From page 2 This is a repeat deficiency. Previously, the 6/10/10 deficiency report included the following: 1. The 6/9/10 review revealed that a background check had been performed for Staff #1 (hired by the former management) in Washington, DC on 2/18/10. Her employment history, however, was not available for verification. No additional information was presented before the survey ended at 3:45 p.m. on 6/10/10. 2. The 6/9/10 review revealed that a background check that covered Maryland, Washington, DC and Virginia had been performed for Staff #2 (hired by the former management) on 9/8/09. Her employment history, however, was not available for verification. No additional information was presented before the survey ended at 3:45 p.m. on 6/10/10. 3. The 6/9/10 review revealed that a background check had been performed for Staff #3 in Washington, DC on 1/13/10. Review of her employment history on 6/10/10 revealed that she had worked in Silver Spring, Maryland from 10/04 - 8/05. Prior to 10/04 (but dates not specified), she had worked in Bladensburg, Maryland. There was no evidence of a background check that covered those jurisdictions. 4. The 6/9/10 review revealed that background checks had been performed for Staff #4 in Washington, DC and Maryland, on 7/2/09 and 2/2/10, respectively. However, review of her employment history on 6/10/10 revealed that she	{R 125}		

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{R 125}	Continued From page 3 had worked in Falls Church, Virginia in 09, and had worked in Danville, Pennsylvania from 5/06 - 8/06. There was no evidence of a background check that covered those jurisdictions. 5. The 6/9/10 review revealed that a background check had been performed for Staff #7 in Washington, DC on 1/12/10. Review of his employment history on 6/10/10 revealed that he had worked in Baton Rouge, Louisiana from 1993 - 5/07. There was no evidence, however, of a background check that covered that jurisdiction. 6. The 6/9/10 review revealed that a background check had been performed for Staff #8 in Washington, DC on 3/31/09. Review of his employment history on 6/10/10 revealed that he had worked in Takoma Park, Maryland from 6/02 - 2005. There was no evidence however, of a background check that covered that jurisdiction. _____ Prior to that, the deficiency report dated 5/3/10, included the following: Of the four newly hired staff, two of the criminal background checks failed to reflect a search was conducted in all areas where they either worked or lived over the past seven years as evidenced below: 1. Record review on 4/29/10, at approximately 12:20 p.m., revealed, Staff #2's job application listed him as either having worked or lived in the states of West Virginia and Pennsylvania within the past seven years. The criminal background check on record at the time of survey only covered the states of Maryland, Virginia and the District of Columbia.	{R 125}		

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{R 125}	Continued From page 4 2. Record review on 4/29/10, at approximately 12:25 p.m., reveated, Staff #3's job application listed him as either having worked or lived in the state of Florida within the past seven years. The criminal background check on record at the time of survey only covered the District of Columbia.	{R 125}		

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{I 000}	INITIAL COMMENTS A second follow-up survey was conducted on 7/13/10 - 7/15/10 to verify that the facility had come into compliance with deficiencies identified in the previous follow-up survey on 6/10/10. The governing body submitted a Plan of Correction dated 7/12/10. The follow-up visit revealed that there had been significant progress made since the 6/10/10 follow-up survey. However, through observation, interviews with staff and residents and review of records, the determination was made that the facility remained not in compliance with 22 DC Municipal Regulations, Chapter 35, Group Homes for Persons with Mental Retardation, as evidenced in the report that follows.	{I 000}		
{I 180}	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, staff interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure the qualified mental retardation professional (QMRP) coordinated, integrated, and monitored services, for five of the five residents residing in the facility. (Residents #1, #2, #3, #4 and #5) The findings include: 1. [Cross-refer to Federal Deficiency Report - Citations W189 and W249] The QMRP failed to ensure that all direct support staff received training on consistent implementation of	{I 180}	1. see W 159 #1	8/18/2010

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{I 180}	Continued From page 1 residents' behavior support plans. According to the QMRP, all five residents had behavior support plans. 2. [Cross-refer to Federal Deficiency Report - Citations W189 and W252] The QMRP failed to ensure that all direct support staff received training on consistent and accurate documentation of behavioral incidents. 3. [Cross-refer to Federal Deficiency Report - Citation W192] The QMRP failed to ensure that direct support staff who were assigned to meal preparation duties were effectively trained on provision of Resident #3's prescribed high fiber diet. 4. There was no evidence that the QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. On 7/13/10, interview with the Director of Nursing by telephone revealed that the facility had just entered into a contract/agreement with a speech/language therapist on the day before (7/12/10). She further indicated that to date, Resident #3 had not received a speech-language screening. This was verified through review of Resident #3's record on 7/14/10. This is a repeat deficiency. --- Previously, the 6/10/10 deficiency report included the following: 2. [Cross-refer to Federal Deficiency Report - Citations W189.1 and W252] The QMRP failed to	{I 180}	See W 159 #2 See W 159 #2a See W 159 #4	8/18/2010 8/18/2010 8/18/2010

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{I 180}	Continued From page 2 ensure that direct support staff received training on consistent and accurate documentation of behavioral incidents. 6. [Cross-refer to Federal Deficiency Report - Citation W460.2] There was no evidence that the QMRP had followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. Citation W460 in the federal deficiency report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the resident was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10, at approximately 5:10 p.m., a direct support staff was observed in the kitchen, chopping food with a knife. When asked, she stated that she and other staff always chopped Resident #3's foods to help his swallowing. However, review of the resident's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food	{I 180}	2. See W 159 #2 6. See W 159 #4	8/18/2010 8/18/2010

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{I 180}	Continued From page 3	{I 180}		
	texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily." [It should be noted that on 6/2/10, a new nutritionist wrote "<Resident #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... <Resident #3> should receive a ground texture."] This is a repeat deficiency. --- Previously, the federal deficiency report dated 5/3/10, included the following: 1. The facility's QMRP failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective for Residents #3 and #4. [See Federal Deficiency Report - Citation W252]		See W 159 #1a	8/18/2010
	2. The facility's QMRP failed to coordinate services to ensure menus were modified as necessary to provide the prescribed diet of Resident #3. [See Federal Deficiency Report - Citation W460]		See W 159 #2a	8/18/2010
{I 222}	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: I. Based on observation, staff interview and record review, the group home for persons with mental retardation (GHMRP) failed to ensure	{I 222}		

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{I 222}	Continued From page 4 staff was effectively trained on implementing residents' behavior support plans and documenting targeted maladaptive behaviors in the residents' behavior data, for 6 of the 13 direct support staff in the facility. The findings include: A. [Cross-refer to W249 and W252] On 7/14/10, at 5:45 p.m., Resident #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the resident was standing alone. However, a direct support staff person began speaking with him from the nearby dining room. The staff did not encourage him to button up and/or zipper his jeans while they conversed. On 7/15/10 at 3:35 p.m., review of Resident #3's behavior data forms revealed that staff had not documented the 5:45 p.m. episode from the previous evening as required by Resident #3's behavior support plan (BSP) dated 4/19/10. Moments later, at 3:40 p.m., the qualified mental retardation professional stated that "staff should direct him to zip his pants up, if he refuses then staff would do it for him." The staff had not, however, been observed implementing the intervention strategies as outlined in the BSP. The facility documented having provided training on residents' programs and data collection on 7/9/10 and 7/13/10. Staff in-service training records were reviewed on 7/14/10. At 11:55 a.m., review of the staff signature sheets revealed that the male staff person who failed to instruct and/or assist Resident #3 with zipping his zipper (later that afternoon, at 5:45 p.m.) had received training on the previous evening (7/13/10). There was no evidence that the	{I 222}	See W 159 #2	8/18/2010

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{I 222}	Continued From page 5 training presented on resident programs and data collection had been effective. B. In addition, further review of the 7/9/10 and 7/13/10 signature sheets revealed that 7 of the 13 direct support staff had attended the trainings. There was no evidence, however, that the other 6 staff had received training on resident programs and data collection. II. Based on observation, interview, and record review, the facility failed to ensure that all staff were effectively trained to implement prescribed diets, for 3 of the 13 direct support staff in the facility. The finding includes: [Cross-refer to Federal Deficiency Report - Citation W460] On 7/13/10, at approximately 5:15 p.m., interview with the direct support staff person who was preparing dinner in the kitchen revealed that all 5 residents, including Resident #3, had received apple sauce for snack. Moments later, review of a list of "low fiber" foods that was posted on a kitchen bulleting board revealed that apple sauce was among the food items considered "low fiber." There was no comparable list of "high fiber" food items posted in the kitchen. Resident #3, who had already finished his apple sauce at the time, had physician's orders that prescribed an "increased fiber" diet. The staff person had prepared stir-fried vegetables with chopped turkey meat, to be served over white rice. When asked about Resident #3's prescribed high fiber diet and how the facility ensures that his meals are high in fiber, the staff person indicated that she wasn't sure and then referred this surveyor to two other	{I 222}	See W 159 #2a	8/18/2010

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{I 222}	Continued From page 6 (male) staff who had been "working here longer." Review of the menu she had used for that evening's meal revealed that it did not address high fiber diet plans. Staff in-service training records were reviewed on 7/14/10. The facility documented that on 6/14/10, the nutritionist presented training on prescribed diets. At 1:30 p.m., review of the 6/14/10 signature sheet revealed that the staff person who prepared the 7/13/10 dinner (and who was interviewed) was one of three current staff who did not attend the nutrition training. Only one of the two male co-workers she had mentioned by name had attended the training. In addition, review of the training materials used on 6/14/10 revealed a list of high fiber foods that recommended brown rice for increased fiber. On 7/13/10, however, Resident #3's stir-fry was served over white rice. This is a repeat deficiency. _____ Previously, the 6/10/10 deficiency report included the following: 1. [Cross-refer to Federal Deficiency Report - Citation W252] On 6/9/10, at approximately 8:15 a.m., Resident #3 was observed to remove all of his clothing while standing in the living room. Review of his records the next day, at 8:55 a.m., revealed that the staff who were on duty at the time failed to document the incident in on his behavior data sheets. Another behavioral incident was indicated in a staff log entry on 6/6/10; however, it too had not been documented in the program book, in accordance with the	{I 222}	1. See W 159 #2	8/18/2010

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	HFD03-0202	A. BUILDING _____ B. WING _____	R 07/15/2010

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{I 222}	Continued From page 7 resident's behavior support plan (BSP), dated 4/19/10. On 6/9/10, at approximately 3:15 p.m., interview with the qualified mental retardation professional (QMRP) revealed that the facility had not provided in-service training since new management was appointed by a court on 5/14/10. This was corroborated a short time later (4:05 p.m.) by two direct support staff who were interviewed. 4. [Cross-refer to Federal Deficiency Report - Citation W460] On 6/9/10, at 4:16 p.m., Resident #3 was offered sugar wafers for afternoon snack. The nutritionist, however, had recommended that he receive hi-fiber snack items, in part to address recurrent bouts of constipation and fecal impactions. Interview with the direct support staff on 6/9/10, at approximately 5:10 p.m., revealed that she was previously unaware of the recommended hi-fiber snacks. She stated that she had not received any training on diet plans and snack choices. She further indicated that there was no list of hi-fiber snacks available for staff reference. On 6/9/10, beginning at 3:11 p.m., the qualified mental retardation professional (QMRP) stated that the facility had not provided staff in-service training since the new management team was appointed on 5/14/10. This was also verified through review of training records on 6/10/10, at approximately 1:00 p.m. [Note: On 6/10/10, at 2:50 p.m., the QMRP pointed to announcements posted in the facility, for mandatory staff training by the nutritionist. It was scheduled for 6/14/10.]	{I 222}	See W 159 #2a	8/18/2010

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{I 227}	Continued From page 8	{I 227}		
{I 227}	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (OPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Based on record review and staff interview, the group home for persons with mental retardation (GHMRP) failed to ensure all staff completed training in performing first aid and cardiopulmonary resuscitation (CPR), for 3 of 4 staff whose training status was reviewed. (Staff #1, #2 and #4) The finding includes: The 6/10/10 survey had identified four staff (S1, S2, S4 and S7) as not having current CPR certification and first aid training. Review of personnel records on 7/14/10, beginning at 11:30 a.m., revealed no evidence that staff S1, S2 and S4 had received CPR certification and first aid training and since the 6/10/10 survey. [Note: Staff #7 was no longer employed by the facility.] Review of the staff in-service training records revealed that CPR and first aid training had been conducted on 7/9/10. When asked about S1, S2 and S4, the qualified mental retardation professional acknowledged that the 3 staff in question still remained without CPR certification and first aid training. However, she then presented a memorandum showing that those 3 staff were registered for the next training, which was scheduled for 7/25/10.	{I 227}	All staff who do not have their CPR and first aid certification will be removed from the schedule until they provide a current certification.	8/11/2010

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{I 227}	Continued From page 9 This is a repeat deficiency. --- On 6/10/10, beginning at 12:37 p.m., review of personnel records revealed no evidence that staff S1, S2, S4 and S7 had current CPR certification and First Aid training. It should be noted that S1 and S2 had been employed by the former residence manager, while S4 and S7 had been employed by the new management, prior to their receivership appointment by a court on 5/14/10. The CEO/administrator acknowledged that some staffs' certifications had expired. He further indicated, however, that the next training had been scheduled for July 2010. This is a repeat deficiency. --- Previously, the licensure deficiency report dated 5/3/10 included the following: Interview with the facility ' s House Manager (HM) on 4/29/10, at approximately 12:10 p.m., revealed the facility has hired four new staff since 12/09. Record review on the same day at approximately 12:55 p.m. revealed, none of the four staff records reviewed showed evidence of either first aid or CPR training. The GHMRP failed to ensure all staff received training in the areas of implementing First Aid or CPR as required by this section.	{I 227}		
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	{I 401}	See W 159 #4	8/18/2010

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{I 401}	Continued From page 10 Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with mental retardation (GHMRP) failed to ensure professional services included timely diagnostic, evaluation, and treatment services to prevent deterioration or further loss of functioning, for one of the five sampled residents. (Resident #3) The finding includes: There was no evidence that the GHMRP followed-up on the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3. On 7/13/10, interview with the Director of Nursing by telephone revealed that the facility had just entered into a contract/agreement with a speech/language therapist on the day before (7/12/10). She further indicated that to date, Resident #3 had not received a speech-language screening. This was verified through review of Resident #3's record on 7/14/10. This is a repeat deficiency. --- Previously, the 6/10/10 deficiency report included the following: Based on observation, interview and record	{I 401}		

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{I 401}	Continued From page 11 review, the facility failed to address the nutritionist's recommendation (4/29/10) to obtain a speech-language screening for Resident #3, as follows: Citation W460 in the Federal Deficiency Report dated 5/3/10, included the following: "According to the <nutritionist's 4/29/10> assessment, the resident was 'having difficulty swallowing regular consistency. Individual holds food in mouth, takes a very long time swallowing. Individual will be able to tolerate a mechanical soft diet. Will notify SLP (speech and language) for screening.' At the time of the survey, however, the SLP screening had not been scheduled." On 6/9/10, at approximately 3:15 p.m., interview with the QMRP revealed that she had not contacted the speech-language therapist (SLP) since she began serving as the QMRP on 5/14/10. She indicated that the facility's executive director planned to call the SLP to schedule appointments. She further indicated that the SLP "has to come. We're going to get everyone an assessment...all of them are outdated." On 6/9/10 at approximately 5:10 p.m., a direct support staff was observed in the kitchen, chopping food with a knife. When asked, she stated that she and other staff always chopped Resident #3's foods to help his swallowing. However, review of the resident's physician's orders failed to show evidence that the recently-assigned PCP had been made aware of the previous recommendations for altered food texture and an SLP screening. On 5/19/10, the PCP wrote the following dietary orders: "Regular, Double portions, High Fiber snacks. Prune juice 1 cup twice daily."	{I 401}		

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{I 401}	Continued From page 12 [It should be noted that on 6/2/10, a new nutritionist wrote "<Resident #3> was assessed for a complete nutrition evaluation...The current diet of mechanical soft texture is synonymous to a ground diet ... <Resident #3> should receive a ground texture."]	{I 401}		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, facility staff failed to consistently implement resident behavior support plans, for one of the five residents included in the sample. (Resident #3) The finding includes: Observation on 7/14/2010 at 5:45 p.m., Resident #3 was observed standing in the living room without a shirt. His jeans were unbuttoned and unzipped. His boxer briefs were exposed. Initially, the resident was standing alone. However, a direct support staff person began speaking with him from the nearby dining room. The staff did not encourage him to button up and/or zipper his jeans while they conversed. On 7/14/2010, at 9:35 a.m., review of Resident #3's behavior support plan (BSP) dated 4/19/10, had revealed "Disrobing" or "removing clothes not in the bathroom/bedroom" was one of several challenging maladaptive behaviors identified in the BSP. In an interview with the qualified mental	I 422	See W 159 #1	8/18/2010

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I 422	Continued From page 13 retardation professional (QMRP) on 7/15/2010, at 3:40 p.m., she stated "staff should direct him to zip his pants up, if he refuses then staff would do it for him."	I 422		